***Assessment Management Tips*: CARE PLAN COMPLETION (VB4)**

	MDS Completion Date (R2b)	RAPs Completion Date (VB2)	Care Plan Completion Date (VB4)
COMPREHENSIVE ASSESSMENTS	**Admission assessment:** No later than Admission date + 13 days **Annual assessment:** ARD + 14 days, but no later than R2b of previous OBRA assessment + 92 days. **Significant Change assessment:** Date of determination + 14 days **Significant Correction of a Prior Full Assessment:** Date of determination of error + 14 days	**Admission assessment:** No later than Admission date + 13 days **Annual assessment:** ARD + 14 days, but no later than VB2 of previous OBRA comprehensive assessment + 366 days. **Significant Change assessment:** Date of determination + 14 days **Significant Correction of a Prior Full Assessment:** Date of determination of error + 14 days	**Admission assessment:** VB2 + 7 days, no later than Admission date + 21 days **Annual assessment:** VB2 + 7 days, no later than ARD + 21 days **Significant Change assessment:** VB2 + 7 days, no later than ARD + 21 days **Significant Correction of a Prior Full Assessment:** VB2 + 7 days, no later than ARD + 21 days

- Care plan development or revision is to be completed with every comprehensive assessment.
- Care Plan Completion Date (VB4) is no later than 7 days following the completion of the RAPs (RAPs Completion Date, VB2).

The following chart provides a summary of the RAI Assessment Schedule.

RAI ASSESSMENT SCHEDULE SUMMARY

Record Type	Completion	Care Plan Completion (VB4)	Submit to State by No Later Than:
Admission	By VB2, no later than Day 14.	VB2 + 7 Days	VB4 + 31 Days
Annual Assessment	Completed within 366 days of most recent comprehensive assessment (VB2 to VB2).	VB2 + 7 Days	VB4 + 31 Days
Significant Change in Status	Must be completed by the end of the 14th calendar day following determination that a significant change has occurred.	VB2 + 7 Days	VB4 + 31 Days
Significant Correction of Prior Full Assessment	Must be completed within 14 days of identification of a major, uncorrected error in a prior comprehensive assessment.	VB2 + 7 Days	VB4 + 31 Days
Quarterly	R2b, no later than 14 days after the ARD, 92 days from R2b to R2b.	N/A	R2b + 31 Days
Significant Correction of Prior Quarterly Assessment	Must be completed within 14 days of the identification of a major, uncorrected error in a prior Quarterly assessment.	N/A	R2b + 31 Days
Discharge Tracking Form	Date of Event at R4 + 7 Days	N/A	R4 + 31Days
Reentry Tracking Form	Date of Event at A4a + 7 Days	N/A	A4a + 31 Days
Correction Request Form	Date at AT6, no later than 14 days after detecting an inaccuracy in an MDS record that has been accepted in State MDS database.	N/A	AT6 + 31 Days

2.4 Tracking Documents: Discharge and Reentry for Nursing Facilities

With MDS Version 2.0, two new forms have been developed to track each resident's "whereabouts" in the health care system. The Discharge and Reentry Tracking forms provide key information to identify and track the movement of residents in and out of the facility.

The Discharge Tracking form contains:

- Section AA (Identification Information), Items 1 through 7,
- A subset of codes from Item AA8a, Primary Reason for Assessment, numbers 6, 7, or 8,
- AB1 (Date of Entry) and AB2 (Admitted From [at Entry]) completed if AA8a = 8,
- A6 (Medical Record Number),
- R3 (Discharge Status) and R4 (Discharge Date).

The Reentry Tracking form contains:

- Section AA (Identification Information), Items 1 through 7,
- A single code from Item AA8a, Primary Reason for Assessment, number 9,
- A4a (Date of Reentry), A4b (Admitted From [at Reentry]) and A6 (Medical Record Number).

Some parts of the State specific Section S may be required with these tracking documents. The Discharge and Reentry documents can be found in Chapter 1. Contact your State RAI Coordinator for specific State requirements.

In some situations, Discharge and Reentry Tracking forms **are not completed**:

- When the resident leaves the facility on a temporary visit home, or on another type of therapeutic or social leave.

- When residents are in a hospital outpatient department for an observational stay of less than 24 hours and the resident is not admitted for acute care as an inpatient.

If the observational stay goes beyond 24 hours or if the resident is admitted for acute care, then a Discharge Tracking form must be completed within seven days. The discharge date entered at R4 would be the date that the resident actually left the facility, not the date he was admitted to the hospital.

The clinician must clearly understand the differences between the three types of discharge in order to correctly select the appropriate response at AA8a. They are:

- Discharged-return not anticipated (Reason for Assessment AA8a = 6)
- Discharged-return anticipated (Reason for Assessment AA8a = 7)
- Discharged prior to completing initial assessment (Reason for Assessment AA8a = 8)

A **Discharge-return not anticipated** (AA8a = 6) is completed when it is determined that the resident is being discharged with no expectation of return after a comprehensive Admission assessment has been completed. A discharge with return not anticipated can be a formal discharge to home, to another facility, or when the resident dies. If the resident is formally discharged from the facility and returns at a later date, this will be a new admission and requires a new Date of Entry (AB1). The MDS assessment schedule will start over with a new comprehensive Admission assessment. If the resident will receive Medicare Part A services, then the Medicare 5-Day assessment would be completed and the Medicare assessment schedule would continue.

A **Discharge-return anticipated** (AA8a = 7) reports a more temporary absence from the facility after the Admission assessment is completed, when it is anticipated that the resident will return for continued nursing facility services. If a resident is temporarily admitted for acute care in the hospital, or a hospital observation stay lasts more than 24 hours, but the resident is expected to return to the nursing facility, the Discharge Tracking form would be coded as a discharge with return anticipated. When the resident returns to the facility, a Reentry Tracking form must be completed to report the return of the resident.

In some situations, a resident may be discharged with a return anticipated and later the facility learns that he/she will not be returning or has died. In this situation, another Discharge Tracking form (return not anticipated) is not necessary unless the State requires this second discharge document. Please contact your State RAI Coordinator for clarification if your state requires this additional Discharge Tracking form.

The **Discharged-prior to completion of the initial assessment** (AA8a = 8) is indicated when a resident is admitted to the facility and the Admission assessment is not completed before the resident is discharged. This reason for assessment should be selected whether or not the resident is expected to return, e.g., from an admission to the hospital, or is not expected to return, e.g., the resident dies in the nursing facility. If the Admission assessment had not been completed, the only discharge that may be selected is AA8a = 8.

If the resident is unstable and has several return visits to the hospital before the Admission assessment is completed, the facility should continue to submit discharges prior to completion of the initial assessment (AA8a = 8) until the resident is in the facility long enough to complete the comprehensive Admission assessment. The same date of entry (AB1) should be used for all these discharges.

In some situations, the resident may be admitted to the skilled nursing unit and a 5-Day Medicare assessment was completed before the resident was admitted to the hospital. If an MDS full assessment or a Medicare Prospective Payment Assessment Form (MPAF) was used, it is not a comprehensive assessment (AA8a = 0 (None of the Above)).

If the resident is admitted to the hospital or the observational stay is longer than 24 hours, a Discharge Tracking form should be completed with the reason for assessment being discharged prior to completing the Admission assessment (AA8a = 8). If the resident returns to the facility, a Reentry Tracking form (see below) is not required, but an Admission assessment (AA8a = 1) must be completed.

A **Reentry** Tracking form (AA8a = 9) is only required if the resident returns to the facility after being discharged – return anticipated (AA8a = 7). If the resident returns after being discharged prior to completing the initial assessment (AA8a = 8), the date of reentry is recorded on the comprehensive Admission assessment at A4a, Date of reentry.

If a resident is in the hospital for a short stay and returns to the facility, the facility can either complete the initial comprehensive admission assessment that was started or start another admission assessment. Any incomplete MDS documents should be saved in the resident's clinical record.

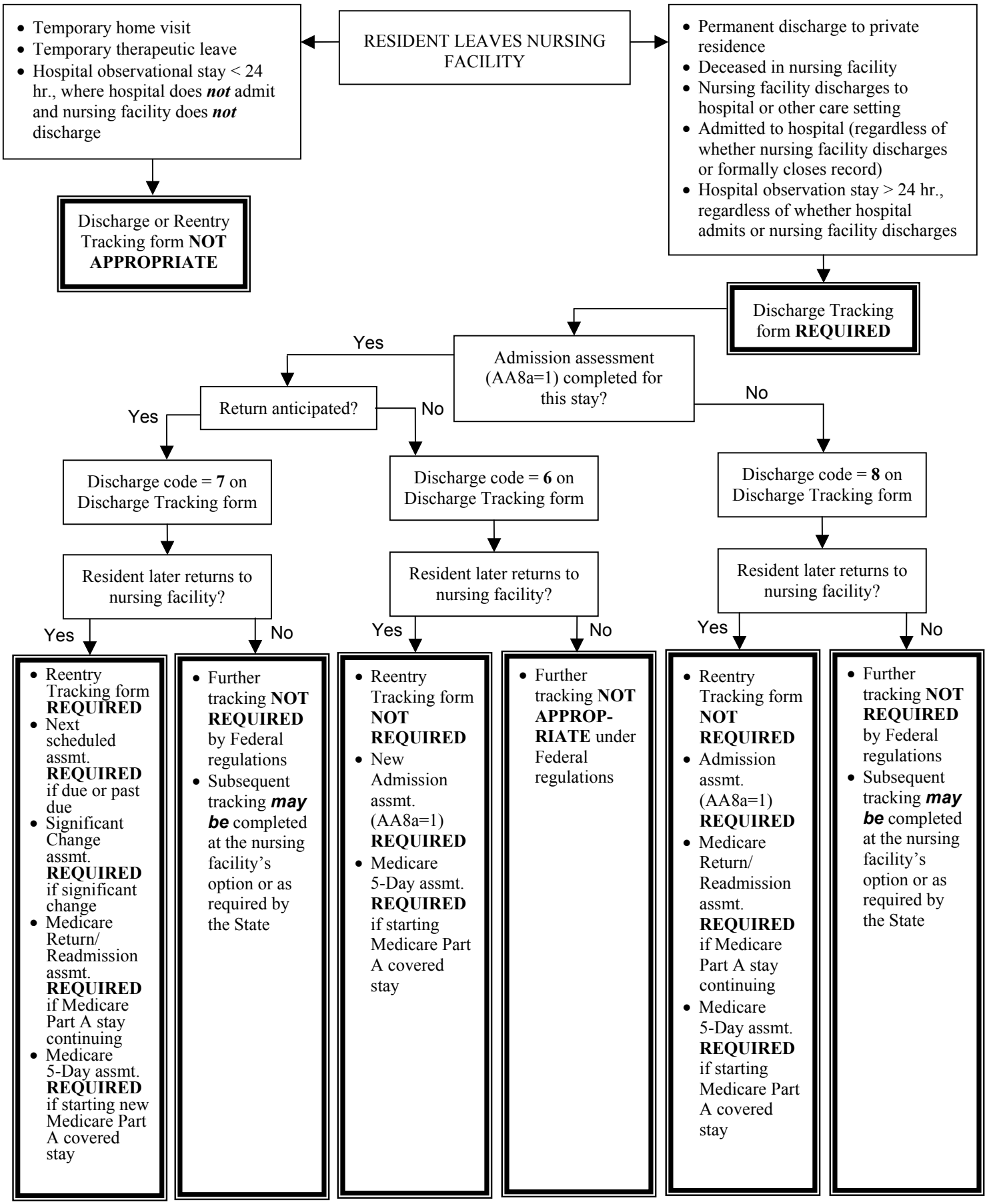
Clarification:

- The requirements for completion of a Discharge Tracking form are not associated with bedhold status. A Discharge Tracking form is required whenever a resident is discharged, regardless of bedhold status. If the bed is being held, it logically follows that return is anticipated, and Item AA8a on the Discharge Tracking form is coded "7" (return anticipated).

  NOTE: The above response assumes that a comprehensive Admission assessment had been completed.

The following chart details the facility's requirement for completion of Discharge and Reentry Tracking forms.

MDS 2.0 DISCHARGE AND REENTRY FLOWCHART



2.5 The SNF Medicare Prospective Payment System Assessment Schedule

Nursing facilities will assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF-level care. The MDS must be completed in compliance with the Medicare schedule as shown in the chart below.

Medicare MDS Assessment Type	Reason for Assessment (AA8b code)	Assessment Reference Date	Assessment Reference Date Grace Days+	Number of Days Authorized for Coverage and Payment	Applicable Medicare Payment Days
5 Day	1	Days 1-5*	6 - 8	14	1 through 14
14 Day	7	Days 11-14	15 - 19	16	15 through 30
30 Day	2	Days 21-29	30 - 34	30	31 through 60
60 Day	3	Days 50-59	60 - 64	30	61 through 90
90 Day	4	Days 80-89	90 - 94	10	91 through 100

*If a resident expires or transfers to another facility before the 5-Day assessment has been completed, the facility will still need to prepare an MDS as completely as possible for the RUG-III Classification and Medicare payment purposes. Otherwise, the days will be paid at the default rate. The Assessment Reference Date must also be adjusted to no later than the date of discharge.

+Grace Days: A specific number of grace days (i.e., days that can be added to the Medicare assessment schedule without penalty) are allowed for setting the Assessment Reference Date (ARD) for each scheduled Medicare assessment.

The Medicare assessment schedule includes a 5-Day, 14-Day, 30-Day, 60-Day and 90-Day assessment. The first day of Medicare Part A coverage is considered Day 1. In most cases, the first day of Medicare Part A eligibility is also the date of admission. However, there are situations where the Medicare beneficiary may only become eligible for Part A services at a later date. See Section 2.9 for more detailed information.

Assessments must also be completed whenever there is a significant change in clinical status or when all therapies are discontinued for a beneficiary who is classified in a RUG-III Rehabilitation group, and that beneficiary continues to require skilled services.

A Readmission/Return assessment must be completed when a beneficiary who was receiving Part A SNF-level services is hospitalized and returns to the SNF and continues to receive Part A SNF-level services.

Assessments performed solely for Medicare payment purposes must be completed within 14 days of the Assessment Reference Date (ARD). The Assessment Reference Date establishes a common reference end-point for all items. The Assessment Reference Date is described in detail in Chapter 3. Nursing facility staff should make every effort to complete assessments in a timely

manner. Each of the Medicare scheduled assessments has defined days when the Assessment Reference Date may be set. For example, for the Medicare 5-Day assessment, days one through five have been defined as the optimal days for setting the Assessment Reference Date. However, there may be situations when an assessment might be delayed and CMS has allowed for these situations by defining a number of grace days for each Medicare assessment. The Medicare 5-Day Assessment Reference Date can be extended one to three grace days.

Grace days can be added to the Assessment Reference Date in situations such as an absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments. The use of grace days allows clinical flexibility in setting ARDs, and should be used sparingly. If a facility chooses to routinely use grace days, it may be subject to review through the survey process, by the fiscal intermediary, or by the Data Assessment and Verification (DAVE) contractor.

A Medicare assessment is considered complete on the day that the registered nurse (RN) coordinating the assessment signs and dates the assessment (MDS Completion Date, R2b). Each MDS record must be encoded and edited at the nursing facility. The MDS records must then be submitted electronically to the State MDS database and will be considered timely if transmitted and accepted into the database within 31 days of completion.

The following chart summarizes the Medicare MDS Assessment Schedule for skilled nursing facilities.

MEDICARE MDS ASSESSMENT SCHEDULE FOR SNFs

Codes for Assessments Required for Medicare	Assessment Reference Date (ARD) Can be set on any of following days	GRACE PERIOD DAYS ARD can also be set on these days	BILLING CYCLE Used by the business office	SPECIAL COMMENT
5 DAY AA8b = 1 AND Readmission/ Return AA8b = 5	Days 1-5	6-8	Set payment rate for Days 1-14	• If a resident transfers or expires before the Medicare 5-Day assessment is finished, prepare an MDS as completely as possible for the RUG Classification and proper Medicare payment, or bill at the default rate. • RAPS must be completed only if the Medicare 5-Day assessment is dually-coded as an Admission assessment or SCSA.
14 Day AA8b = 7	Days 11-14	15-19	Set payment rate for Days 15-30	• RAPs must be completed only if the 14-Day assessment was dually coded as an Admission or Significant Change in Status assessment. • Grace period days do not apply when RAPs are required on a dually coded assessment, e.g., Admission assessment.
30 Day AA8b = 2	Days 21-29	30-34	Set payment rate for Days 31-60	
60 Day AA8b = 3	Days 50-59	60-64	Set payment rate for Days 61-90	
90 Day AA8b = 4	Days 80-89	90-94	Set payment rate for Days 91-100	• Be careful when using grace days for a Medicare 90-Day assessment. The completion date of the Quarterly (R2b) must be no more than 92 days after the R2b of the prior OBRA assessment.
Other Medicare Required Assessment (OMRA)	• 8 - 10 days after all therapy (PT, OT, ST) services are discontinued and resident continues to require skilled care. • The first non-therapy day counts as day 1.	N/A	Set payment rate effective with the ARD	• Not required if the resident has been determined to no longer meet Medicare skilled level of care. • Establishes a new non-therapy RUG Classification. • Not required if the resident is dis-charged from Medicare prior to day 8. • Not required if not previously in a RUG-III Rehabilitation group
Significant Change in Status Assessment (SCSA)	Completed by the end of the 14th calendar day following determination that a significant change has occurred.	N/A	Set payment rate effective with the ARD	• Could establish a new RUG Classification and remains effective until the next assessment is completed.

***NOTE:** Significant Correction assessments are not required for Medicare assessments that have not been combined with an OBRA assessment. See Chapter 5 for detailed instructions on the correction process.

2.6 Types of MDS Medicare Assessments for SNFs

The MDS has been constructed to identify the OBRA Reasons for Assessment in Items AA8a and A8a. If the assessment is being used for Medicare reimbursement, the Medicare Reason for Assessment must be coded in Item AA8b and A8b. The Medicare and State reasons for assessment are described in this section. In many cases, assessments are combined to meet both OBRA and Medicare requirements. The relationship between OBRA and Medicare assessments are discussed below and in more detail in Section 2.8.

Codes for Assessments Required for Medicare or in States When Required - It is possible to select a code for the MDS from both AA8a and AA8b (e.g., Item AA8a coded "3" (Significant Change in Status assessment), and Item AA8b coded "3" (60-Day assessment).

1. **Medicare 5-Day Assessment** - The first Medicare assessment completed upon admission to the nursing facility for Part A SNF-level services. The 5-Day Medicare assessment must have an ARD (Item A3a) established between days 1-5 of the SNF stay. The ARD (Item A3a) can be extended to day 8 if using the designated "Grace Days." The 5-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 14-day calculation is based on calendar days and includes weekends. The 5-Day assessment authorizes payment from days 1 through 14 of the stay, as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If combined with the Admission assessment, then the assessment must be completed at VB2 by day 14 of admission.

2. **Medicare 30-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 21-29 of the SNF stay. The ARD (Item A3a) can be extended to day 34 if using the designated "Grace Days." The 30-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 30-Day assessment authorizes payment from days 31 through 60 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

3. **Medicare 60-Day assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 50-59 of the SNF stay or as long as the resident remains eligible for Part A SNF-level services. The ARD (Item A3a) can be extended to day 64 if using the designated "Grace Days." The 60-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 60-Day assessment authorizes payment from days 61 through 90 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

4. **Medicare 90-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 80-89 of the SNF stay. The ARD (Item A3a) can be extended to day 94 if using the designated "Grace Days." The 90-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 90-Day assessment authorizes payment from days 91 through 100 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). (NOTE: When combined with an OBRA Quarterly assessment, see Section 2.2).

5. **Medicare Readmission/Return Assessment** - Medicare assessment that is completed when a resident whose stay was being reimbursed by Medicare Part A was hospitalized, discharged, and later readmitted to the SNF from the hospital. The Readmission/Return assessment, like the 5-Day assessment, must have an ARD (Item A3a) established between days 1-8 of the return. The Readmission/Return assessment must be completed (Item R2b) within 14 days of the ARD. The Readmission/Return assessment restarts the Medicare schedule and the next required assessment would be the Medicare 14-Day assessment. The MDS records must be submitted electronically, and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

6. **Other State-Required Assessment – This assessment is not used for Medicare purposes.** In some cases, States have established assessment requirements in addition to the OBRA and Medicare assessments. Contact your RAI Coordinator for State specific requirements.

7. **Medicare 14-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 11-14 of the SNF stay or as long as the resident remains eligible for Part A SNF-level services. The ARD (Item A3a) can be extended to day 19 if using the designated "Grace Days." The 14-Day assessment must be completed (Item R2b) within 14 days of the ARD. The 14-Day assessment authorizes payment from days 15 through 30 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If combined with the Admission assessment, then the assessment must be completed at VB2 by day 14 of admission. (NOTE: When combined with an OBRA Admission assessment, see instructions in Sections 2.2 and 2.8.)

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8. **Other Medicare-Required Assessment** - The OMRA is completed only if the resident was in a RUG-III Rehabilitation Classification and will continue to need Part A SNF-level services after the discontinuation of therapy. The last day in which therapy treatment was furnished is day zero. The OMRA ARD (Item A3a) must be set on day eight, nine, or ten after all rehabilitation therapies have been discontinued. The OMRA must be completed (Item R2b) within 14 days of the ARD. The OMRA will establish a new non-therapy RUG-III group and Medicare payment rate. The MDS records must be submitted electronically, and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If the OMRA falls in the assessment window of a regularly schedule Medicare assessment, code the assessment as an OMRA to affect the change in payment status.

2.7 The Medicare Prospective Payment System Assessment Form (MPAF)

Effective July 1, 2002, skilled nursing facilities may choose to complete and submit a shorter version of the MDS called the Medicare Prospective Payment System Assessment Form (MPAF), rather than a full Minimum Data Set (MDS) assessment for Medicare assessments. The MPAF provides facilities with options concerning the forms used for Medicare assessments. The MPAF consists of a subset of the MDS items that includes:

- Items for resident identification,
- Items necessary to complete the Resource Utilization Group-III calculation, and
- Items needed to calculate the Quality Indicators (QIs).

Although the MPAF has fewer items than the full MDS, the included item-by-item definitions and coding instructions are identical. The item-by-item information is not repeated in this section. Refer to the item-by-item definitions in Chapter 3. A copy of the MPAF form is in Chapter 1.

The MPAF was implemented effective July 1, 2002. Skilled nursing facilities have the option of using the MPAF rather than the full MDS assessment when performing many of the required Medicare assessments. Use of the MPAF is completely optional. If a facility continues to submit a full MDS assessment for Medicare, the extra MDS items (those not on the MPAF) will be ignored and will not be edited or stored in the State MDS database. No errors or warnings will occur because a full assessment is submitted for Medicare. NOTE: Facilities should work with their software vendors to update their systems to include the MPAF option.

When assessments are completed for both OBRA reasons and Medicare, all OBRA-required items, all Medicare-required items, and any State-specific items (Section S) must be submitted, with all required items being stored in the State MDS database. When assessments are Medicare (no OBRA reason present), only the MPAF items and any State-specific items (Section S) will be active and stored in the State MDS database.

The MPAF optional form cannot be used for a Significant Change in Status Assessment or Significant Correction of a Prior Full assessment. These are comprehensive assessments and require the full MDS, RAPs, and care planning. However, the MPAF can be used for an OMRA when it is not combined with any other comprehensive assessment.

The State may not require additional MDS items on Medicare assessments. However, the State may require State-specific items in Section S on all MDS records, including Medicare assessments. If Section S is required on Medicare assessments, then the Section S items must be submitted. CMS has approved the MPAF for use as a Quarterly assessment. A state may adopt the MPAF form as the State-specified Quarterly assessment by sending written notification to CMS.

The following are the form requirements and assessment options for different types of MDS records including the MPAF.

***Scenarios 1-3 are situations when the MPAF may be used.**

Scenario 1

The Clinician is Completing a Medicare Assessment

Reason for Assessment:
AA8a = 00 None of the Above
AA8b =1 Medicare 5 day assessment
2 Medicare 30 day assessments
3 Medicare 60 day assessments
4 Medicare 90 day assessments
5 Medicare Readmission/Return assessments
7 Medicare 14 day assessments
8 Other Medicare required assessment

Full Assessment Option

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. That exception is that AB5a through AB5f (items included on the MPAF form) can be optionally submitted alone (without other face sheet items).
- Full assessment form is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by State.

MPAF Assessment Option

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. The exception is that AB5a through AB5f (items included on the MPAF form) can be submitted alone (without other face sheet items).
- MPAF form is required.
- Section S can be required by State.

Scenario 2

The Clinician is Completing a Medicare Assessment Combined with an OBRA Quarterly Assessment **In a State That Uses a RUG-III Quarterly as the State-Specified Assessment**

Reason for Assessment:
AA8a = 05 Quarterly review assessment
10 Significant Correction of Prior Quarterly assessment
AA8b = 1 Medicare 5 Day assessment
2 Medicare 30 Day assessments
3 Medicare 60 Day assessments
4 Medicare 90 Day assessments
5 Medicare Readmission/Return assessments
7 Medicare 14 Day assessments
8 Other Medicare-required assessment

Full Assessment Option

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. That exception is that AB5a through AB5f (items included on the MPAF form) can be optionally submitted alone (without other face sheet items).
- Full assessment form is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by State.

MPAF Assessment Option

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. The exception is that AB5a through AB5f (items included on the MPAF form) can be submitted alone (without other face sheet items).
- MPAF form is required.
- Section S can be required by State.

Scenario 3

The Clinician is Completing a Medicare Assessment Combined with an OBRA Quarterly Assessment **In a State That Uses a Minimum Quarterly as the State-Specified Assessment**

Reason for Assessment:
AA8a = 05 Quarterly review assessment
10 Significant Correction of Prior Quarterly assessment
AA8b =1 Medicare 5 Day assessment
2 Medicare 30 Day assessments
3 Medicare 60 Day assessments
4 Medicare 90 Day assessments
5 Medicare Readmission/Return assessments
7 Medicare 14 Day assessments
8 Other Medicare-required assessment

Full Assessment Option

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. That exception is that AB5a through AB5f (items included on the MPAF form) can be optionally submitted alone (without other face sheet items).
- Full MDS assessment form is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by State.

MPAF Assessment Option

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. The exception is that AB5a through AB5f (items included on the MPAF form) can be submitted alone (without other face sheet items).
- MPAF form is required.
- Section S can be required by State.

***Scenarios 4-6 are situations when the MPAF may not be used.**

Scenario 4

The Clinician is Completing a Medicare Assessment Combined with an OBRA Admission Assessment

Reason for Assessment:
AA8a = 01 Admission assessment (required by day 14)
AA8b =1 Medicare 5 Day assessment
5 Medicare Readmission/Return assessments
7 Medicare 14 Day assessments
8 Other Medicare-required assessment

Full Assessment Required for All OBRA Admission Assessments

- Assessment tracking form (Section AA) is required.
- Background (face sheet) form is required.
- Full MDS assessment form is required.
- RAP Summary form (Section V) is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by the State.

Scenario 5

The Clinician is Completing a Medicare Assessment Combined with an OBRA Comprehensive Assessment Other Than an Admission

Reason for Assessment:
AA8a = 02 Annual assessment
03 Significant Change in Status assessment
04 Significant Correction of Prior Full assessment
AA8b =1 Medicare 5 Day assessment
2 Medicare 30 Day assessments
3 Medicare 60 Day assessments
4 Medicare 90 Day assessments
5 Medicare Readmission/Return assessments
7 Medicare 14 Day assessments
8 Other Medicare-required assessment

Full Assessment Required for All OBRA Comprehensive Assessments

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. That exception is that AB5a through AB5f (items included on the MPAF form) can be optionally submitted alone (without other face sheet items).
- Full MDS assessment form is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by State.

Scenario 6

The Clinician is Completing a Medicare Assessment Combined with an OBRA Quarterly Assessment **In a State That Requires a Full MDS Assessment**

Reason for Assessment:
AA8a = 05 Quarterly review assessment
10 Significant Correction of Prior Quarterly assessment
AA8b =1 Medicare 5 Day assessment
2 Medicare 30 Day assessments
3 Medicare 60 Day assessments
4 Medicare 90 Day assessments
5 Medicare Readmission/Return assessments
7 Medicare 14 Day assessments
8 Other Medicare-required assessment

Full Quarterly Assessment Required by the State

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. That exception is that AB5a through AB5f (items included on the MPAF form) can be optionally submitted alone (without other face sheet items).
- Full MDS assessment form is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by State.

2.8 Combining the RAI OBRA Schedule with the Medicare Schedule for SNFs

SNF providers are required to meet two assessment standards in a Medicare certified facility:

- The OBRA standards, requiring comprehensive assessments on admission, annually, when a significant change in status occurs or when a Significant Correction of a Prior Full assessment is required. Quarterly assessments are also required on the form designated by the State. These assessments are designated by the reason selected in AA8a, Primary Reason for Assessment.

- The Medicare standards, requiring assessments for payment for a resident in a Medicare Part A stay at 5-day, 14-day, 30-day, 60-day and 90-day time frames. An OMRA assessment must also be completed when a resident who was in a RUG-III Rehabilitation Classification, had all therapies discontinued, and continues a Part A stay due to other skilled needs. These assessments are designated by the reason selected in AA8b, codes for assessments required for Medicare or the State. If the assessment is completed only for Medicare (AA8a = 00), then either the full MDS or MPAF form can be used.

When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. When combining the OBRA and Medicare assessments, the most stringent requirement for MDS completion must be met. For example, an Admission assessment, including RAPs, must be completed within the first 14 days of the resident's stay. The requirements for Medicare specify that facilities must complete two assessments for each resident in a Medicare covered Part A stay – a 5-Day and a 14-Day.

There is no need to complete three separate assessments: the Admission assessment may be combined with either the 5-Day (AA8a = 01, AA8b = 1) or the 14-Day (AA8a = 01, AA8b = 7). However, the Admission assessment would have to be a comprehensive assessment with RAPs, not the shorter form that may be completed for Medicare assessments. The other assessment completed in the 14-day period solely for Medicare would be done using either the full MDS or the optional MPAF form (AA8a = 00, AA8b = 1 or 7 as applicable).

The nursing facility must be very careful in selecting the ARD for an Admission assessment combined with a 14-Day Medicare assessment. For the admission standard, the ARD must be set between Days 1 to 14. For Medicare, the ARD must be set between Days 11 and 14, but the regulation allows grace days up to Day 19. However, when combining a 14-Day Medicare assessment with the Admission assessment, grace days are not allowed. To assure, in this situation, that the assessment meets both standards, an ARD between Days 11 and 14 would have to be chosen.

Any OBRA assessment and any Medicare assessment may be combined in this way as long as the ARD and completion date (R2b or VB2) meet both requirements, and the most stringent completion timeframe requirement is met. For example, often the Quarterly assessment and the 90-Day Medicare assessment are due in the same time period. The facility must assure that the completion date (R2b) will occur within 92 days of the R2b of the previous comprehensive or Quarterly

assessment. The ARD must also be set within the proper window for the Medicare requirement. Then the facility must decide which form to complete.

- If the State requires only a two page or RUG-III Quarterly, for an assessment designated as AA8a = 05 and AA8b = 4, either a full MDS or MPAF would be completed. The full MDS or MPAF is the more extensive MDS form; the most stringent requirement must be met.

- If the State requires a full assessment for a Quarterly, for an assessment designated as AA8a = 05 and AA8b = 4, a full MDS form must be completed. It is the more extensive MDS form; the most stringent requirement must be met.

NOTE: It is extremely important to understand the MDS requirements established in your state. Your decision to use the MPAF may be dependent upon your State Medicaid agency's MDS assessment requirements and the State-designated Quarterly assessment.

For a resident who was already in the nursing facility but is now beginning a new Medicare Part A stay, it might be appropriate to combine a Quarterly with a Medicare 5-Day, depending on the resident's status.

A Significant Change in Status assessment might be combined with any Medicare assessment including an OMRA, presuming that the ARD is within the assigned Medicare assessment window and the assessment is completed within 14 days of the identification of the change. At all times, when the nursing facility chooses to complete one assessment to meet both an OBRA and a Medicare requirement, staff must carefully review the standards for each assessment to assure that the most stringent requirement is met.

2.9 Factors Impacting the SNF Medicare Assessment Schedule

Resident Expires or Transfers

If a beneficiary expires or transfers to another facility before the 5-Day assessment is completed, the nursing facility prepares a Medicare assessment as completely as possible to obtain the RUG-III Classification so the provider can bill for the appropriate days. If the Medicare assessment is not completed then the nursing facility provider will have to bill at the default rate.

Resident Discharges to Hospital Prior to the Admission Assessment Completion

Since the Admission assessment was not completed, the facility must complete a Discharge Tracking form with a reason for assessment A8a = 8, discharged prior to completion of admission assessment. In most cases, the facility will have completed a 5-Day Medicare assessment covering the period from the date of admission to the earlier of the Assessment Reference Date (which can be assigned up through day 8 of the Part A stay) or the actual date of discharge. This Medicare assessment will be needed to bill for Part A days.

When the beneficiary returns, the facility completes the Admission (OBRA) assessment by continuing the assessment started prior to the hospital stay (and completing it within 14 days of the initial date of admission) or completes a new assessment within 14 days of the reentry date. In addition, the facility must complete a Medicare Readmission/Return assessment coded AA8b = 5. Generally the Admission assessment can be combined with either the Medicare Readmission/Return assessment or the Medicare 14-Day assessment.

Resident is Admitted to an Acute Care Facility and Returns

If a Medicare resident is admitted to an acute care facility and later returns to the SNF, the Medicare assessment schedule is restarted with the Medicare Readmission/Return assessment followed by the 14-Day, 30-Day, etc. A Discharge Tracking form, return anticipated and a Reentry Tracking form, would precede this.

If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted, the Medicare assessment schedule is not restarted. However, there are payment implications, since the day preceding the midnight on which the resident was absent from the facility is not a covered Part A day. This is known as the "midnight rule." The Medicare schedule must then be adjusted. The day preceding the midnight is not a covered Part A day and therefore, the Medicare assessment "clock" is adjusted by skipping that day in calculating when the next Medicare assessment is due.

Resident Leaves the Facility and Returns During the Middle of an ARD Period

The ARD is not altered if the beneficiary is out of the facility for a temporary leave of absence during part of the observation period. In this case, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines - see Chapter 3) but may not extend the observation period.

Resident Discharged from Skilled Services and Returns to SNF-Level Services

The beneficiary is discharged from Medicare Part A services but remains in the facility in a certified bed with another pay source. Since the beneficiary remained in a certified bed after the Medicare benefits were discontinued, the facility must continue with the OBRA schedule from the beneficiary's original date of admission. There is no reason to change the OBRA schedule when Part A benefits resume. When the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day assessment, MDS Item AA8b = 1.

The original date of entry (AB1) is retained. The beneficiary should be assessed to determine if there was a significant change in status. An SCSA could be completed with either the Medicare 5-Day or 14-Day assessment.

Resident in a Part A Stay Begins Therapy

Adding therapy services to the treatments furnished to a beneficiary in a Part A stay does not automatically require a new assessment. However, if the therapy was added because the beneficiary experienced a significant change, an SCSA must be completed. In this case, the primary reason for assessment would be a SCSA (A8a = 3). If the SCSA is done during a Medicare assessment

window, the SCSA can be combined with a regularly scheduled Medicare assessment. If the SCSA is not within a Medicare assessment window, the Medicare reason for assessment should be coded as AA8a = 3 and AA8b = 8, Other Medicare Required assessment.

Physician Hold Occurs

If a physician hold occurs or 30 days has elapsed since a level of care change, the nursing facility provider will start the Medicare assessment schedule on the first day that Part A SNF-level services started. An example of a physician hold could occur when a resident is admitted to the nursing facility for rehabilitation services but is not ready for weight-bearing exercises. The physician will write an order to start therapy when the resident is able to do weight bearing. Once the resident is able to start the therapy, the Medicare Part A stay begins, and the Medicare 5-Day assessment will be completed. Day "1" of the stay will be the first day that the resident is able to start therapy services.

Combining Assessments

Significant Change in Status Assessment (SCSA) or the Other Medicare Required Assessment (OMRA) may be combined with the regularly scheduled Medicare assessments. If the Medicare assessment window coincides with the SCSA assessment, a single assessment may be coded as both a regularly scheduled assessment (e.g., 5-Day, 14-Day, 30-Day, 60-Day, or 90-Day) and an SCSA. If the Assessment Reference Date of an OMRA coincides with a regularly scheduled Medicare assessment, it is coded only as the OMRA. For billing purposes, it is identified as an OMRA replacing a 14-Day, 30-Day, 60-Day or 90-Day.

Currently there is no way to code that a SCSA performed outside the assessment window is a Medicare assessment. Until this problem can be corrected, code AA8a = 3 to show the SCSA and AA8b = 8 to indicate that the record is a Medicare assessment. This procedure is an exception to the rule that OMRAs are performed only to show discontinuation of therapy for residents in a RUG-III Rehabilitation Classification. In some circumstances, an SCSA can be used as an OMRA and a scheduled Medicare assessment.

Non-Compliance with the Assessment Schedule

According to the Code of Federal Regulation (CFR) section 413.343, assessments that fail to comply with the assessment schedule will be paid at the default rate. Frequent early or late assessment scheduling practices may result in onsite review.

Early Assessment

An assessment should be completed according to the designated Medicare assessment schedule. If an assessment is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-Day assessment with an ARD of day 10 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

Default Rate

MDS assessments are completed according to an assessment schedule specifically designed for Medicare payment, and each assessment applies to specific days within a resident's SNF stay to determine the appropriate reimbursement for the resident. Compliance with this assessment schedule is critical to ensure that the appropriate level of payment is established. Accordingly, SNFs that fail to perform assessments timely are to be paid a RUG-III default rate for the days of a resident's care for which they are not in compliance with this schedule. The RUG-III default rate takes the place of the otherwise applicable Federal rate. The RUG-III default rate is equal to the rate paid for the RUG-III group reflecting the lowest acuity level, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Late or Missed Assessment Criteria

A late or missed assessment may be completed as long as the window for the allowable ARD (including grace days) has not passed. If a late/missed assessment has an ARD within the allowable grace period, no financial penalty is assessed. If the assessment has an ARD after the mandated grace period, payment will be made at the default rate for covered services from the first day of the coverage period to the ARD of the late assessment. A late assessment cannot replace the next regularly scheduled assessment. Therefore, if the ARD of the 14-Day assessment was day 22, it cannot be used as both the Medicare 14-Day and Medicare 30-Day assessments.

In this situation, the late 14-Day assessment would be used to support payment for days 22-30 of the Part A stay. A new 30-Day assessment would need to be completed within the assessment window for the Medicare 30-Day assessment.

Errors on a Medicare Assessment

To correct an error on an MDS that has been submitted to the State, the facility must follow the normal MDS correction procedures (see Chapter 5).

- **Modification:** This procedure should be used if any of the item responses were incorrect, e.g., Medicare number, number of therapy minutes, etc.
- **Inactivation:** This procedure should be used if the assessment itself was invalid, e.g., the Reason for Assessment for Medicare (AA8b) was incorrect. This might be an assessment completed to meet the 30-Day assessment requirement, but incorrectly submitted as a 60-Day assessment. The assessment should be resubmitted with the corrected reason for assessment.

A Significant Correction assessment is not done when the assessment in error has been completed to meet the Medicare schedule only. However, if the assessment had been completed to meet an OBRA requirement, as well as the Medicare schedule, normal MDS correction procedures might require the completion of a Significant Change in Status assessment or a Significant Correction assessment, depending on the type of errors identified. Payment will be based on the new Assessment Reference Date if appropriate. Correction procedures are explained in detail in Chapter 5.